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Your Dental Benefits

The Verizon Dental Expense Plan (the Plan) is designed to provide you and your family with comprehensive dental care coverage. The Plan includes:

- Options that allow you to choose the most appropriate coverage for you and your family, as well as the option to waive coverage if you are covered as a dependent under another Verizon-sponsored Dental Plan or if you are a part-time associate who does not receive the full Company subsidy for dental coverage
- Preventive care coverage that encourages regular checkups
- Coverage for corrective care and orthodontia services.

About This SPD

This book is the summary plan description (SPD) for the Verizon Dental Expense Plan for Mid-Atlantic Associates (including eligible CWA and IBEW employees of Verizon). The Plan is subject to federal law under the Employee Retirement Income Security Act of 1974 (ERISA) and its subsequent amendments. This book meets ERISA's requirements for an SPD and is based on Plan provisions effective January 1, 2001. It updates and replaces all previous SPDs and other descriptions of the benefits provided by the Plan. This SPD is part of this Plan.

This SPD is divided into the following major sections:

- **Participating in the Plan.** This section explains your eligibility, which of your dependents are eligible to be covered and when eligibility ends.
- **Overview of Your Options.** This section describes the dental options available to you. Refer to it when deciding which option to choose and when you need information about your coverage and benefits.

Dental Expense Plan for Mid-Atlantic Associates

The Verizon Dental Expense Plan for Mid-Atlantic Associates is a component plan of Verizon Plan 550. Plan 550 provides other benefits to eligible employees, as described on [page 54](#).

This SPD describes Plan benefits for Verizon Mid-Atlantic CWA and IBEW associates. Plan 550 also provides benefits for Connected Solutions Inc. technicians. These benefits are described in another SPD.

Important Note

Verizon and its claims and appeals administrators have the discretionary authority to interpret the terms of this SPD and determine your eligibility for benefits under its terms.

- **Preferred Dentist Program (PDP) Option.** With this option, you have the freedom to use any dentist, but you benefit from discounted rates and a higher level of benefit coverage when you use a participating dentist.
- **Out-of-Area Option.** This is an option if you live outside the PDP's participating provider network area.
- **Standard Option.** This option works like a traditional dental plan. You may use any dentist you choose.
- **Dental Maintenance Organization (DMO) Option.** With this option, you can receive a high level of coverage but you must use a DMO dentist.
- **Continuing Coverage.** In some cases, you and/or your dependents can continue coverage even after eligibility for the Plan ends.
- **What Is Not Covered.** This section lists services and supplies not covered under the Plan.
- **How to File a Claim.** This section provides information on when you need to file a claim to receive benefits.
- **Additional Information.** This section provides additional details about the administrative provisions of the Plan and your legal rights.
- **Glossary.** Certain terms used in this SPD are defined in the glossary.

Getting More Information

If you have questions about your benefits or need additional information after reading this SPD, you have the following resources:

- **For general information about the Plan,** call Verizon's Bell Atlantic InTouch Center (or its successor) at the telephone number listed on your Important Benefits Contacts insert. The voice response system is available 24 hours a day, seven days a week. InTouch Representatives are available to answer your questions from 8:00 a.m. to 5:00 p.m. Eastern time, Monday through Friday (excluding holidays).
- **For specific details about coverage provisions,** call the applicable claims and appeals administrator's Member Services telephone number directly (see your Important Benefits Contacts insert for the telephone numbers).

Every effort has been made to ensure the accuracy of the information included in this SPD, which constitutes part of the Plan document, as restated effective January 1, 2001. Copies of Plan documents are available by contacting the Plan administrator in writing at the address provided on [page 49](#) in the “Additional Information” section.

Changes to the Plan

While the Company expects to continue the Plan indefinitely, the Verizon Employee Benefits Committee (VEBC), formerly named the Bell Atlantic Corporate Employees’ Benefits Committee, also reserves the right to amend, modify, suspend or terminate the Plan at any time, at its discretion, with or without advance notice to participants, subject to any duty to bargain collectively. The Plan may be amended by publication of any SPD, summary of material modification, enrollment materials or other communication relating to the Plan, as approved by the chairperson of the VEBC or an individual in a Director level position or above in the employee benefit design or delivery or the communications branch of the Company’s Human Resources organization. The Company also reserves the right to change the amount of required participant contributions for coverage under the Plan at any time, with or without advance notice to participants, subject to any duty to bargain collectively.

Decisions regarding changes to, or terminations of, benefits are made at the highest levels of management. Verizon employees below those levels do not know whether the Company will adopt any particular change and are not in a position to speculate about such changes. Unless and until changes formally are adopted and officially are announced, no one is authorized to assure that any particular change will or will not occur.

Participating in the Plan

Eligibility

You are eligible for Plan coverage after you have completed three months of net credited service if you are employed by a Verizon participating company (see [page 55](#)) and are a regular or term full-time or part-time CWA-represented or IBEW-represented Mid-Atlantic associate. A term associate is an associate whose employment is intended to last more than six months and not more than 30 months. A term associate's employment ends upon completion of the specific project for which he or she is hired.

“Service” is based on net credited service provisions of the Verizon Pension Plan for Mid-Atlantic Associates.

You are not eligible to participate in the Plan if any one of the following applies:

- You are paid by a temporary staffing or placement agency or other vendor or third party.
- You are employed under the terms of a written agreement with the Company as an independent contractor or consultant.
- You are paid through accounts payable instead of the payroll system.
- You are a working retiree. (Working retirees continue dental coverage under the Verizon Dental Expense Plan for Mid-Atlantic Post-1989 Associate Retirees.)

Note: If a court, the Internal Revenue Service or any other enforcement authority or agency finds that an independent contractor or leased employee should be treated as a regular employee of a participating company, for example, for purposes of W-2 income reporting or tax withholding, such individual is nonetheless expressly excluded from the definition of eligible employee and is expressly ineligible for benefits under the Plan.

Eligible Dependents

Dependents must be enrolled through the InTouch Center to have coverage. You can enroll only your eligible dependents who meet the Plan definition for eligibility, as described below.

Dependent Eligibility Requirements		
Dependent Class	Who They Are	Relationship
Class I Dependents	<ul style="list-style-type: none"> Your legal spouse (a legally separated spouse is not eligible) Your unmarried children until the end of the calendar year in which they reach age 19, provided they receive more than 50% of their support from you. Children means children by birth, as well as legally adopted children (or children placed for adoption), stepchildren who live in your home and children who live in your home and for whom you or your spouse is the legal guardian or has legal custody Your unmarried children (as defined above) from age 19 through the end of the calendar year in which they reach age 25 and are full-time students at an accredited educational institution (provided they receive more than 50% of their support from you) until the end of the month they no longer qualify as full-time students or, if earlier, the end of the calendar year in which they reach age 25 Your unmarried children (as defined above) of any age who are dependent on you for support due to physical or mental disability (if the disability began before age 19 or before age 25 while a full-time student and they were covered continuously) Your same-sex domestic partner and his or her children may be eligible for coverage. For more information on eligibility requirements and tax implications, call the InTouch Center and speak with a representative Your unmarried children (as defined above and including any age requirements) who are alternate recipients under an approved qualified medical child support order (QMCSO) 	<ul style="list-style-type: none"> Spouse Child Full-Time Student Disabled Child Domestic Partner Domestic Partner's Child Child
Sponsored Children	Your unmarried children from age 19 through the end of the calendar year in which they reach age 25 who are not full-time students or incapacitated and otherwise meet the definition of child, as described above	Sponsored Child

Note: Grandfathered Class II Dependents and Sponsored Parents are not eligible for coverage under the Plan.

Qualified Medical Child Support Order

If you are required to provide dental coverage to a child pursuant to a court- or state agency-issued qualified medical child support order (QMCSO), the Plan will allow you to cover that child in accordance with procedures established by the Plan administrator. For a copy of the procedures, contact the Qualified Order Team at the telephone number listed on your Important Benefits Contacts insert.

Note: If you (and your covered dependents) have Dental Maintenance Organization (DMO) coverage as of the effective date of an approved QMCSO and the recipient child does not live in a DMO service area, your coverage automatically will change as follows:

- If you are a CWA-represented associate, you and your dependents will have Preferred Dentist Program (PDP) or Out-of-Area coverage, depending on your home ZIP code.
- If you are an IBEW-represented associate, you and your dependents will have Standard Option coverage.

If Your Spouse or Same-Sex Domestic Partner Is a Verizon Employee or Retiree

For dental coverage, if your spouse or same-sex domestic partner is employed by or retired from Verizon or affiliates, the following rules apply:

- Children can be covered by one Verizon parent or the other, but not by both.
- You can be covered as an employee or retiree or as a dependent under a Verizon-sponsored Dental Plan, but not as both. To be covered as a dependent under another plan, you must choose the waiver of coverage option under this Plan.
- Your spouse or same-sex domestic partner can be covered as an employee or retiree or as a dependent under a Verizon-sponsored Dental Plan, but not as both. To be covered as your dependent under this Plan, your spouse or same-sex domestic partner must be eligible for and must choose the waiver of coverage option under his or her plan. If he or she is not eligible to choose the waiver of coverage option under his or her plan, your spouse or same-sex domestic partner cannot be covered under your Plan.

Enrolling in the Plan

Initial Enrollment by Newly Hired Associates

The following enrollment rules apply based on your work schedule:

- If you are a full-time associate or a part-time associate who is scheduled to work 25 or more hours a week, your dental coverage begins automatically on the first day of the month in which you attain three months of net credited service.
- If you are a part-time associate, other than a member of IBEW Local 1944, scheduled to work less than 25 hours a week who has been employed continuously by the Company since before January 1, 1981, your dental coverage begins automatically on the first day of the month in which you attain three months of net credited service.

How Do I Enroll or Make Changes?

Call the InTouch Center at the telephone number listed on your Important Benefits Contacts insert. The voice response system is available 24 hours a day, seven days a week. InTouch Representatives are available to help you from 8:00 a.m. to 5:00 p.m. Eastern time, Monday through Friday (excluding holidays).

- If you are a part-time IBEW Local 1944 associate scheduled to work less than 25 hours a week or you are any other eligible part-time associate who has not been employed continuously by the Company since before January 1, 1981, you must enroll through the InTouch Center to have dental coverage. You can enroll after you complete three months of net credited service and agree to pay the required cost by payroll deductions; otherwise, you will not have coverage. If you enroll on or before the deadline shown on your Enrollment Worksheet, your coverage takes effect on the first day of the month in which you reach three months of net credited service. For example, if your hire date is June 20, your coverage is effective September 1. If you do not enroll by the deadline, you must wait until the open enrollment period or, if sooner, when you have a status change (see [pages 9 through 11](#)).
- If you are a retired participant covered under retiree dental benefits who is rehired by the Company and you are not a working retiree, you automatically are enrolled for dental coverage on the first day of the month after your date of rehire.
- If you are changing from a management position to a full-time associate position or a part-time position in which you're scheduled to work 25 or more hours a week, your dental coverage begins automatically on the first day of the month following the date your payroll changes for the change in position. If you are changing to a part-time position in which you are scheduled to work less than 25 hours a week, you must enroll to have coverage.

Enrollment Worksheet
<p>Before your three-month enrollment date or if you change from a management position to an associate position, the InTouch Center will send you an Enrollment Worksheet with your dental coverage options listed.</p>

If you want to choose coverage under an option available to you, you must call the InTouch Center by the deadline shown on your Enrollment Worksheet for that coverage to begin the first day of the month in which you attain three months of net credited service. If you are eligible for automatic coverage (see [page 6](#)) and do not enroll, you will have coverage for yourself only under the applicable automatic coverage option (see “If You Do Not Enroll,” [page 8](#)). This coverage will continue until the next open enrollment period or until you have a change in status for which a change in coverage is allowed. If you want to choose coverage under another option available to you, you must call the InTouch Center. Available options include:

- For CWA-represented associates: PDP (see [pages 18 through 23](#))
- For CWA-represented associates whose home ZIP code is outside the PDP service area: Out-of-Area option (see [pages 24 through 25](#))
- For IBEW-represented associates: Standard Option (see [pages 26 through 29](#))

- For both IBEW- and CWA-represented associates: DMO (see [pages 30 through 31](#))
- For both IBEW- and CWA-represented associates who are covered as dependents under another Verizon-sponsored Dental Plan or who are part-time associates who do not receive the full Company subsidy for dental coverage: Waiver of dental coverage (see [page 32](#)).

You also must call the InTouch Center to enroll any eligible dependent you want included under your coverage. You can choose coverage for yourself plus one dependent or for yourself plus two or more dependents. However, Sponsored Children are enrolled in a separate category. You'll need to provide each dependent's name, date of birth and Social Security number. If you enroll eligible dependents before the deadline shown on your Enrollment Worksheet, their coverage begins on the same date as your coverage. Otherwise, coverage begins the first day of the month after you enroll them.

If You Do Not Enroll

If you automatically are eligible for coverage based on your work schedule (see [pages 6 through 7](#)), the option in which you are enrolled if you do not choose another option by your enrollment deadline depends on the bargaining agreement that covers you:

- **If you are a CWA-represented associate**, your automatic coverage option is the PDP or Out-of-Area option, depending on your home ZIP code.
- **If you are an IBEW-represented associate**, your automatic coverage option is the Standard Option.

Changing Your Elections

Open Enrollment

Each year during the open enrollment period, you will have an opportunity to change your elections. Elections made during the open enrollment period take effect on the following January 1 and remain in effect through December 31 of that year, unless you change the election during the year due to a change in status.

Part-Time Associates Enrollment

If you are an eligible part-time associate working less than 25 hours per week and are a member of IBEW Local 1944 or have not been employed continuously since before January 1, 1981, you must call the InTouch Center to enroll for dental coverage; otherwise, you will have no coverage.

DMO Enrollment

The DMO may have additional rules concerning enrollment or changes in enrollment. Call Member Services for details.

Status Changes

Between open enrollment periods, you may be able to change your Dental Plan option and covered dependents if you or a dependent has a change in status that affects eligibility for coverage. An election change can be made due to a change in status if the election change is on account of and corresponds with a change in status that affects eligibility for coverage under an employer's plan. Elections made due to status changes remain in effect until you make a change during an open enrollment period or due to another status change.

You Gain a New Dependent

If you gain a new, eligible dependent through marriage, acquisition of a same-sex domestic partner, birth, adoption or placement for adoption, that person automatically is covered under your dental coverage option for 31 days after the event. If you want dental coverage to continue for the new dependent, you must call the InTouch Center to enroll that dependent in the Plan; otherwise, coverage will end for that dependent after 31 days.

- Your election will take effect on the date that you gained the new dependent, if you make your election within 31 days of gaining the new dependent.
- Coverage will begin again for the new dependent on the first day of the month following your election, if you make your election more than 31 days after the event.

Note: If you disenroll a same-sex domestic partner, you must wait 60 days before you can enroll a new same-sex domestic partner.

If you gain a new, eligible dependent as the result of a QMCSO, you can enroll that dependent in the Plan by calling the InTouch Center. Your election will take effect on the date the QMCSO is approved by the claims administrator.

If you gain a new, eligible dependent as the result of an event other than those listed above—for example, a dependent child age 23 starts attending school full-time after a period of ineligibility due to age—you can enroll that dependent in the Plan by calling the InTouch Center. Your election will take effect the first of the month following your election.

You Lose a Dependent Through Death, Legal Separation, Divorce or Termination of a Same-Sex Domestic Partnership

If you lose a dependent through death, legal separation, divorce or termination of a same-sex domestic partnership, coverage for that dependent ends on the date of the event. However, you must notify the Company by calling the InTouch Center to remove that dependent from your coverage; otherwise, you will continue to pay any required premiums.

A Dependent Loses Eligibility

If a dependent loses eligibility for the Plan, the dependent's coverage will continue until the end of the month in which the event occurs that causes the dependent to lose eligibility. An exception occurs if the dependent is a child who loses eligibility because he or she reaches an age limit for coverage. In this case, the child's coverage will continue until December 31 of the year in which the age limit is reached. However, if the child reaches the age 25 limit and is a full-time student who graduates prior to December 31 of his or her 25th year or no longer maintains his or her full-time student status, his or her coverage will terminate at the end of the month in which he or she loses full-time student status.

When a dependent loses eligibility, you must notify the Company by calling the InTouch Center before the dependent's coverage ends. Even if you do not notify the Company, you are responsible for any claims and expenses incurred after the date the coverage should have ended.

A Dependent Changes Eligibility Class

If a dependent loses eligibility as a Class I Dependent but would be eligible for coverage as a Sponsored Child, you must notify the Company by calling the InTouch Center within 31 days of the change in eligibility to ensure your dependent's coverage will continue without interruption. If you do not notify the InTouch Center of the change within 31 days, the dependent's coverage will cease until notification is received. When notification is received, coverage will be reinstated on the first day of the month following notification.

You Move

If you move to a new residence during the Plan year and that move affects your coverage (e.g., if you are covered by the DMO option and you move out of the DMO service area), you can change your Dental Plan option. You must call the InTouch Center to make a change.

Your Dentist Stops Participation

If your dentist stops participating in the Plan during the Plan year, you cannot change your option. You must wait until the next open enrollment period or until you experience a status change to change your Dental Plan option.

Special Enrollment Rules

If you or your dependents (including your spouse or same-sex domestic partner) waived dental coverage because of other dental insurance coverage, you may be able to enroll yourself or your dependents in the Plan if you later lose that other insurance due to:

- Loss of eligibility
- Termination of employer contributions for such coverage
- Exhaustion of COBRA coverage.

If you enroll yourself or your dependents in the Plan:

- Within 31 days of losing the other coverage, your coverage will be effective retroactive to the date of the event
- After 31 days of losing the other coverage, your coverage will be effective the first day of the month following your enrollment.

In addition, if you gain a new dependent as a result of marriage, birth, adoption, placement for adoption or acquisition of a same-sex domestic partner and his or her children, you may be able to enroll yourself and your dependents. If you enroll:

- Within 31 days of the event, your coverage will be effective retroactive to the date of the event
- After 31 days following the event, your coverage will be effective the first day of the month following your enrollment.

Cost of Coverage

The Company pays the full cost of dental coverage for you and your enrolled Class I Dependents if you have at least three months of net credited service and are as follows:

- A regular or term full-time associate working at least 25 hours a week
- A part-time associate, other than a member of IBEW Local 1944, hired before January 1, 1981 and continuously employed by the Company since that date.

If you are a member of IBEW Local 1944 or if you have not been employed continuously by the Company since before January 1, 1981 and you work at least 17 but less than 25 hours a week, the Company contributes 50 percent of the amount it contributes for full-time employees. In order to have coverage, you must enroll and agree to pay the other 50 percent of the cost by payroll deduction.

If you are a member of IBEW Local 1944 or if you have not been employed continuously by the Company since before January 1, 1981 and you work less than 17 hours a week, you can enroll for coverage if you call the InTouch Center and agree to pay the full cost.

You pay the full cost of coverage for any Sponsored Children whom you choose to cover.

If you cover a same-sex domestic partner and his or her dependents whom you do not claim as dependents for federal tax purposes, the Company is required by tax law to impute income to you based on the fair market value of the coverage provided to your same-sex domestic partner and his or her dependents.

When Participation Ends

This section explains when participation in the Plan ends for you and your dependents.

Associate Coverage

An associate's coverage will end on the earliest date described below.

Leaves of Absence

In general, if you go on a leave of absence, your coverage continues in accordance with Company guidelines.

- **Leaves of Absence Under the Family and Medical Leave Act.** The Company complies with the Family and Medical Leave Act of 1993 (FMLA). All leaves of absence qualifying under the FMLA will be administered in accordance with the terms of the FMLA. Coverage may be continued during approved leaves, as provided in Company policy. Call the InTouch Center for details.
- **Leaves of Absence Under the Uniformed Services Employment and Reemployment Rights Act.** All military leaves of absence qualifying under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) will be administered in accordance with the terms of USERRA.
- **Union Leaves of Absence.** Under a Union Leave of Absence, coverage can be continued according to your collective bargaining agreement.

- **Anticipated Disability Leaves of Absence, Care of Newborn Child Leaves of Absence and Dependent Care Leaves of Absence.** Under an Anticipated Disability Leave of Absence, a Care of Newborn Child Leave of Absence or a Dependent Care Leave of Absence, Verizon will pay the amount it normally does for your coverage. If you contribute to the cost of your dental coverage, however, you must continue making contributions during your leave. The Company will bill you monthly for these charges.
- **Education Leaves of Absence or Personal Leaves of Absence.** If you take an Education Leave of Absence or Personal Leave of Absence, coverage for you and your eligible dependents will end on the last day of the month in which your leave begins.

Change in Employment Status

If your employment status changes from associate to management status, coverage under the Plan will end on the last day of the month in which you become a manager of the Company or an affiliate of the Company.

Long-Term Disability

If you are receiving long-term disability benefits, coverage under the Plan will end on the last day of the month in which your employment ends due to long-term disability.

Cancellation of Coverage

If you cancel coverage due to a change in status, your coverage will end on the last day of the month in which you elect to cancel coverage.

Failure to Submit Payment (If Required)

If you are required to make a payment and it is not received on time, coverage will end on the first day of the month for which payment is not received.

End of Employment

Coverage under the Plan will end on the last day of the month in which your employment ends for any reason not specified in this section.

Plan Termination

Although the Company does not intend to terminate the Plan, were the Plan to be terminated, all coverage would end on the date of termination.

Important Note

If you retire from the Company and meet eligibility requirements, you may qualify to elect retiree coverage under the Plan.

Dependent Coverage

A dependent's coverage will end on the earliest date described in the following section.

Associate's Coverage Ends

If the associate's coverage ends for any reason except when the associate dies, coverage for all dependents also will end at the same time.

Associate Dies

When the associate dies, coverage for all dependents will end on the last day of the month in which the associate dies.

Dependent Ceases to Meet the Eligibility Requirements

A dependent's coverage will end on the earlier of either the date the dependent is covered as an employee or retiree under any Company-sponsored Dental Plan or the last day of the month in which the dependent no longer qualifies as a dependent under the Plan, subject to the following:

- Coverage for your spouse ends on the day he or she becomes legally separated or divorced from you.
- Coverage for a same-sex domestic partner ends on the day he or she fails to meet the definition of a same-sex domestic partner.
- Coverage for a child ends on the last day of the calendar year in which he or she reaches age 19 (if not a full-time student), or the last day of the month in which the child is married, if earlier.
- Coverage for a stepchild ends on the last day of the month in which he or she no longer lives with you.
- Coverage for a full-time student ends on the earlier of the last day of the calendar year in which the student reaches age 25 or the last day of the month in which he or she no longer qualifies as a full-time student.
- Coverage for a disabled child ends on the last day of the month in which he or she no longer meets the definition of a disabled child.
- Coverage for a Sponsored Child ends on the earlier of the last day of the calendar year in which the child reaches age 25 or the last day of the month for which a required contribution is not received.

Notify the InTouch Center If a Dependent Is Ineligible

It is your responsibility to notify the InTouch Center if your dependents no longer meet eligibility requirements.

Periodically, you may be asked to provide proof of your dependents' eligibility. If such proof is not provided, those dependents will lose their eligibility for the Plan, effective retroactively as of the date determined by the Plan administrator.

Any claims incurred by an ineligible dependent become your financial responsibility. Your dependent also may lose the right to purchase continued dental care benefits under COBRA if you do not notify the InTouch Center within 60 days of a dependent losing eligibility. Call the InTouch Center for details.

- Coverage for a child under a QMCSO ends on the date the associate no longer is required to provide coverage for this child or, if earlier, the date the child no longer would be eligible for coverage, as defined on [page 5](#).
- Coverage for a child of a same-sex domestic partner ends on the last day of the calendar Plan year in which the child reaches age 19 or age 25 (if a full-time student), as applicable, or the last day of the month in which the child otherwise fails to meet the definition of a child of a partner (or the partner no longer meets the definition of a same-sex domestic partner), as defined on [page 5](#).

Extended Benefits

Your dental coverage will continue while you receive benefits from the Verizon Sickness and Accident Disability Benefit Plan for Mid-Atlantic Associates if you pay required contributions, if any.

In addition, the Plan will pay benefits for the following services, supplies and treatment received after your coverage otherwise would end, as long as the service, supply or treatment is installed or delivered within two months following the date coverage otherwise would end:

- A prosthesis, including bridgework, if the impressions were taken and the abutment teeth were prepared fully before coverage otherwise would end
- A crown, if the tooth was prepared before coverage otherwise would end
- Root canal therapy, if the tooth was opened before coverage otherwise would end.

Certificate of Coverage

When any person's coverage under the Plan ends for any reason, including the end of COBRA continuation coverage, the Company will send that person a Certificate of Creditable Coverage, as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This certificate may help the person receive coverage under another plan. Additional certificates may be requested by the former employee or dependent at any time within 24 months of the date on which the person's coverage ends. To request a certificate, call the InTouch Center.

Continuation of Coverage Under COBRA

In some instances, a person whose eligibility for coverage under this Plan ends still may be able to continue coverage in accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and its subsequent amendments. Continuation of coverage under COBRA is described on [pages 33 through 36](#) of this summary plan description (SPD).

Overview of Your Options

Dental Plan Options

The Plan includes a range of options to help you meet your dental needs. The options available to you depend on the bargaining agreement that covers you:

- For CWA-represented associates: Preferred Dentist Program (PDP) option (see [pages 18 through 23](#))
- For CWA-represented associates whose home ZIP code is outside the PDP service area: Out-of-Area option (see [pages 24 through 25](#))
- For IBEW-represented associates: Standard Option (see [pages 26 through 29](#))
- For both IBEW- and CWA-represented associates: Dental Maintenance Organization (DMO) option (see [pages 30 through 31](#))
- For both IBEW- and CWA-represented associates who are covered as dependents under another Verizon-sponsored Dental Plan or who are part-time associates who do not receive the full Company subsidy for dental coverage: Waiver of dental coverage (see [page 32](#)).

Alternative Procedures

Regardless of the coverage option you choose, if there are two or more ways of effectively treating your dental condition, benefits will be payable based on the cost of the least expensive treatment that's appropriate, as determined by the claims administrator. You will be responsible for all charges above the amount considered for the least expensive treatment. Your dentist provides all dental recommendations related to your treatment.

Predetermination of Benefits

Regardless of the coverage option you choose, if dental treatment is expected to cost more than \$300, you should request that your dentist complete a Predetermination of Benefits Form, available from the claims administrator, to indicate the intended treatment and estimated fees to the claims administrator. The claims administrator considers the dentist's recommended treatment as well as alternative treatments, and then notifies you and your dentist of the benefits payable under the Plan.

If you do not get a predetermination of benefits, the claims administrator will make the determination of what the Plan will pay when the claim is received.

Important Note

If you already have been approved for treatment and there is a slight change in your course of treatment, you do not have to refile for predetermination of benefits. However, for major changes in treatment, you should refile.

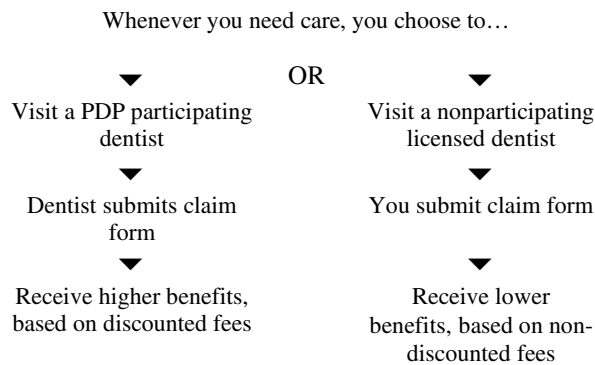
Preferred Dentist Program Option

The Preferred Dentist Program (PDP) option is available to CWA-represented associates whose home ZIP code is in a PDP service area.

Under the PDP, when you need care, you can visit any dentist. The same expenses are covered whether or not you use a participating provider. However, when you use a dentist in the PDP network, you are charged preferred rates, which are discounted fees. In addition, you receive the highest benefits available under the option and you do not have to meet a deductible.

If you receive covered services outside the network, you must meet an annual deductible before the option pays benefits for basic restorative or major restorative services; the option pays a lower percentage of covered services; and you are responsible for any amount charged over the preferred rate.

The chart below describes how the PDP works.



A list of participating dentists can be obtained by calling MetLife at the telephone number listed on your Important Benefits Contacts insert. MetLife also has an Internet site where you can get information about participating dentists online.

Important Note

Your eligibility for the PDP is based on your home ZIP code. If the PDP is not shown as an option on your Enrollment Worksheet because you do not live in a PDP service area, you may be able to opt-in to the PDP. (Speak with an InTouch Representative for details.)

Annual Deductible

When you use nonparticipating dentists, you must pay an annual \$50 deductible per person before the option pays benefits for basic restorative, major restorative or orthodontic services. There is no deductible required for preventive and diagnostic care. There is no family limit. Expenses for non-covered services or supplies do not count toward the deductible.

Benefit Maximums

The annual maximum benefit the option will pay is \$1,500 per person, per calendar year. No more than \$1,000 per person will be paid when nonparticipating providers are used for covered services and supplies. This applies to all covered dental benefits combined, except orthodontia.

Orthodontic services are subject to a separate lifetime benefit limit of \$2,000 per person. No more than \$1,000 per person will be paid when nonparticipating providers are used for covered services and supplies.

How Benefits Are Determined

The same expenses are covered regardless of the dentist you use. However, when you use PDP participating dentists, your share of expenses generally will be less because you are charged preferred rates. Preferred rates are negotiated by the administrator and usually are less than fees charged by nonparticipating dentists. In addition, the option pays a higher percentage of covered expenses and you do not have to meet a deductible.

Preventive and Diagnostic Care

In general, the option pays 100 percent of covered preventive and diagnostic care services based on the preferred rate, whether you use a participating dentist or a nonparticipating dentist. If you use a nonparticipating dentist, there is no deductible, but you must pay any amount that is over the preferred rate. (See [page 21](#) for covered services and supplies.)

Basic Restorative Care

If you receive basic restorative care from a participating dentist, the option pays 80 percent of the preferred rate.

If you receive basic restorative care from a nonparticipating dentist, the option pays 70 percent of the preferred rate after you meet the deductible. If your dentist charges more than the preferred rate, you also must pay the amount above the preferred rate. (See [page 22](#) for covered services and supplies.)

Important Note

The lifetime orthodontic benefit maximum is a single lifetime maximum for all Verizon coverage. If you or any individual you cover meets the benefit maximum for orthodontia, that individual does not gain a new lifetime orthodontic benefit maximum if you change options.

Important Note

Even if you visit a participating dentist for a service or supply that is **not** covered by the PDP option, your expenses still will be lower than using a nonparticipating dentist because you will be charged the preferred rate.

Major Restorative Care

If you receive major restorative care from a participating dentist, the option pays 65 percent of the preferred rate.

If you receive major restorative care from a nonparticipating dentist, the option pays 50 percent of the preferred rate after you meet the deductible. If your dentist charges more than the preferred rate, you also must pay the amount above the preferred rate. (See [page 23](#) for covered services and supplies.)

Orthodontic Care

If you receive orthodontic care from a participating dentist, the option pays 60 percent of the preferred rate.

If you receive orthodontic care from a nonparticipating dentist, the option pays 50 percent of the preferred rate after you meet the deductible. If your dentist charges more than the preferred rate, you also must pay the amount above the preferred rate. However, if the Verizon Employee Benefits Committee (VEBC) determines that there is an insufficient number of participating orthodontists in your service area, the option will pay 60 percent of your orthodontist's charge, and the deductible does not apply. (See [page 23](#) for covered services and supplies.)

Overview of Benefits

Option Feature	Using Participating Dentists	Using Nonparticipating Dentists
Annual deductible—does not apply to preventive and diagnostic care	Not applicable	\$50 per person; no family limit
Annual benefit maximum, excluding orthodontia	\$1,500 per person ¹	\$1,000 per person ¹
Orthodontic lifetime benefit maximum	\$2,000 per person ^{2,3}	\$1,000 per person ^{2,3}
<p>Preventive and Diagnostic Care (Frequency limits are per person)</p> <p>Routine oral exam: Two per calendar year. Additional exams are covered as needed specifically for emergency confirmation of diagnosis of suspected disease or injury, as long as no other covered services or supplies are rendered on the same day</p> <p>Cleaning and scaling of teeth: Twice per calendar year</p> <p>Single film X rays: As needed to diagnose a specific condition, except for orthodontia</p> <p>Complete x-ray series, including panoramic film and bitewing X rays or a single panoramic film: Once every 3 calendar years if ordered by a dentist</p> <p>Supplementary bitewing X rays: Twice each calendar year if ordered by a dentist</p> <p>Topical fluoride treatment: Once per calendar year</p> <p>Panoramic survey, including maxillary and mandibular: Once every 3 calendar years</p> <p>Fabrication, insertion and adjustment of a non-orthodontic space maintainer for patients under age 19 only: As needed for replacement of prematurely lost or extracted teeth</p>	Option pays 100% of preferred rate	Option pays 100% of preferred rate

¹Note that the \$1,000 maximum when using nonparticipating dentists counts toward the \$1,500 maximum when using participating providers (so if you receive \$1,000 in benefits using nonparticipating dentists, you are eligible to receive an additional \$500 in benefits from participating providers).

²Note that the \$1,000 maximum when using nonparticipating dentists counts toward the \$2,000 maximum when using participating providers (so if you receive \$1,000 in benefits using nonparticipating dentists, you are eligible to receive an additional \$1,000 in benefits from participating providers).

³The lifetime orthodontic benefit maximum is a single lifetime maximum for all Verizon coverage and is in addition to the separate annual benefit maximum.

Option Feature	Using Participating Dentists	Using Nonparticipating Dentists
<p>Basic Restorative Care</p> <p>Oral surgery, including:</p> <ul style="list-style-type: none"> • Incision and draining of abscess • Simple extractions • Surgical removal of soft tissue impactions; exception: if you live in Pennsylvania, New Jersey or Delaware, you must submit these expenses to your medical plan first • Removal of partial or complete bony impactions <p>30 minutes of intravenous sedation or general anesthesia, in connection with oral surgery</p> <p>Fillings made from amalgam, silicate, acrylic or plastic, composite acrylic resin. Multiple fillings in one surface are considered a single filling</p> <p>Root canal therapy (including X rays, tests, lab exams and follow-up care) for devitalized teeth only, including X rays and cultures in conjunction with a surgical procedure</p> <p>Periodontics, including:</p> <ul style="list-style-type: none"> • Gingival curettage • Gingivectomy • Osseous surgery • Periodontal surgery • Scaling and root planing: Limited to one full mouth procedure every 24 months <p>If more than one surgery is performed at the same time, the more comprehensive procedure is covered by the option</p> <p>Additions to partial dentures to replace extracted teeth</p> <p>Tooth sealants to permanent non-restored molars; for covered individuals who are under age 19 only: Once per tooth every 5 calendar years</p>	<p>Option pays 80% of preferred rate</p>	<p>Option pays 70% of preferred rate</p>

Option Feature	Using Participating Dentists	Using Nonparticipating Dentists
<p>Major Restorative Care Inlay restorations, if the tooth cannot be restored by other means because of extensive caries or traumatic injury</p> <p>Crowns (single restorations), if the tooth cannot be restored by other means because of extensive caries or traumatic injury: Once every 5 calendar years</p> <p>Initial installation of fixed bridges, bridge pontics or crowns</p> <p>Repair or re-cementing of crowns, inlays, bridgework or dentures</p> <p>Initial installation of partial or full removable dentures, including adjustments to such dentures within 6 months of initial installation</p> <p>Initial installation of a permanent full denture that replaces a temporary denture if it is installed within 12 months of the temporary denture</p> <p>Replacement or modification of an existing full removable or partial denture or fixed bridge if it was installed at least 5 years prior to its replacement or additional extractions required the replacement</p> <p>Lab costs for relining complete upper or lower dentures, excluding relining within 6 months of insertion</p> <p>Replacement of congenitally missing teeth</p> <p>Diagnosis and non-surgical treatment of temporomandibular joint dysfunction, if the treatment is not otherwise excluded from coverage</p> <p>Occlusal devices for teeth grinding (bruxism): Necessity determined by the Plan administrator</p>	<p>Option pays 65% of preferred rate</p>	<p>Option pays 50% of preferred rate</p>
<p>Orthodontic Care Services for the detection, prevention and correction of malocclusion of teeth in relation to the jaw</p>	<p>Option pays 60% of preferred rate</p>	<p>Option pays 50% of preferred rate⁴</p>

⁴Option pays 60 percent of your orthodontist's charges if the VEBC determines there is a limited number of participating orthodontists in your service area. The deductible does not apply.

Out-of-Area Option

The Out-of-Area option is available to CWA-represented associates whose home ZIP code is outside the Preferred Dentist Program (PDP) service area.

The Out-of-Area option covers the same services and supplies as the PDP option (see [pages 21 through 23](#)). However, the Out-of-Area option pays the same percentage of benefits based on reasonable and customary (R&C) amounts regardless of the dentist you choose. If your dentist charges more than the R&C amount, you are responsible for the portion above the R&C amount. You do not have to meet a deductible before the option pays benefits for covered services and supplies.

Benefit Maximums

The annual maximum benefit the option will pay is \$1,500 per person per calendar year. This applies to all covered dental benefits combined, except orthodontia.

Orthodontic services are subject to a separate lifetime benefit limit of \$2,000 per person.

How Benefits Are Determined

The Out-of-Area option pays benefits based on the type of covered service or supply you receive. You can use any dentist you choose.

Preventive and Diagnostic Care

In general, the option pays 100 percent of R&C for covered preventive and diagnostic care (see [page 21](#) for covered services and supplies). If your dentist charges more than the R&C amount, you are responsible for the portion above the R&C amount.

Basic Restorative Care

The option pays 80 percent of R&C for covered basic restorative care (see [page 22](#) for covered services and supplies). If your dentist charges more than the R&C amount, you are responsible for the portion above the R&C amount.

Important Notes

- You cannot opt-in to the Out-of-Area option.
- The lifetime orthodontic benefit maximum is a single lifetime maximum for all Verizon coverage. If you or any individual you cover meets the benefit maximum for orthodontia, that individual does not gain a new lifetime orthodontic benefit maximum if you change options.
- Even if you enroll in the Out-of-Area option, you can visit a dentist who participates in the PDP network. If you do, your expenses will be lower because you will be charged the preferred rate.

Major Restorative Care

The option pays 65 percent of R&C for covered major restorative care (see [page 23](#) for covered services and supplies). If your dentist charges more than the R&C amount, you are responsible for the portion above the R&C amount.

Orthodontic Care

The option pays 60 percent of R&C for covered orthodontic care (see [page 23](#) for covered services and supplies). If your dentist charges more than the R&C amount, you are responsible for the portion above the R&C amount.

Standard Option

The Standard Option is available to IBEW-represented associates.

The Standard Option is a traditional “indemnity” option. You can choose any dentist and receive benefits for covered services from the option.

Benefit Maximums

The annual maximum benefit the option will pay is \$1,500 per person per calendar year. This applies to all covered dental benefits combined, except orthodontia.

Orthodontic services are subject to a separate lifetime benefit limit of \$2,000 per person.

How Benefits Are Determined

The Standard Option pays benefits based on the type of covered service or supply you receive. You can use any dentist you choose.

Preventive and Diagnostic Care

In general, the option pays 100 percent of reasonable and customary (R&C) amounts for covered preventive and diagnostic care (see [page 27](#) for covered services and supplies). If your dentist charges more than the R&C amount, you are responsible for the portion above the R&C amount.

Basic Care

The option pays benefits for covered basic care according to a schedule of benefits (see [pages 28 through 29](#) for covered services and supplies). If your dentist charges more than the scheduled amount, you are responsible for the portion above the scheduled amount.

For the scheduled benefit for a specific service, call Aetna USHC Member Services (see your Important Benefits Contacts insert for the telephone number).

Major Care

The option pays benefits for covered major care according to a schedule of benefits (see [pages 28 through 29](#) for covered services and supplies). If your dentist charges more than the scheduled amount, you are responsible for the portion above the scheduled amount.

Important Note

The lifetime orthodontic benefit maximum is a single lifetime maximum for all Verizon coverage. If you or any individual you cover meets the benefit maximum for orthodontia, that individual does not gain a new lifetime orthodontic benefit maximum if you change options.

For the scheduled benefit for a particular procedure, call Aetna USHC Member Services (see your Important Benefits Contacts insert for the telephone number).

Orthodontic Care

The option pays benefits for covered orthodontic care according to a schedule of benefits (see [pages 28 through 29](#) for covered services and supplies). If your dentist charges more than the scheduled amount, you are responsible for the portion above the scheduled amount.

For the scheduled benefit for a specific orthodontic service, call Aetna USHC Member Services (see your Important Benefits Contacts insert for the telephone number).

Overview of Benefits

Option Feature	Benefit
Annual benefit maximum, excluding orthodontia	\$1,500 per person
Orthodontic lifetime benefit maximum	\$2,000 per person ¹
<p>Preventive and Diagnostic Care (Frequency limits are per person)</p> <p>Routine oral exam: Two per calendar year; additional exams are covered as needed specifically for emergency confirmation of diagnosis of suspected disease or injury, as long as no other covered services or supplies are rendered on the same day</p> <p>Cleaning and scaling of teeth: Twice per calendar year</p> <p>Single film X rays: As needed to diagnose a specific condition, except for orthodontia</p> <p>Complete x-ray series, including panoramic film and bitewing X rays or a single panoramic film: Once every 3 calendar years if ordered by a dentist</p> <p>Supplementary bitewing X rays: Twice each calendar year if ordered by a dentist</p> <p>Topical fluoride treatment: Once per calendar year</p> <p>Panoramic survey, including maxillary and mandibular: Once every 3 calendar years</p> <p>Fabrication, insertion and adjustment of a non-orthodontic space maintainer for patients under age 19 only: As needed for replacement of prematurely lost or extracted teeth</p> <p>Tooth sealants to permanent non-restored molars; for dependents under age 19 only: Once every 5 calendar years</p>	Option pays 100% of R&C

¹The lifetime orthodontic benefit maximum is a single lifetime maximum for all Verizon coverage and is in addition to the separate annual benefit maximum.

Option Feature	Benefit
<p>Basic, Major and Orthodontic Care</p> <p>Oral surgery, including:</p> <ul style="list-style-type: none"> • Incision and draining of abscess • Simple extractions • Surgical removal of soft tissue impactions • Removal of partial or complete bony impactions <p>General anesthesia in connection with oral surgery</p> <p>Fillings made from amalgam, acrylic or plastic, composite acrylic resin</p> <p>Root canal therapy (including X rays, tests, lab exams and follow-up care) for devitalized teeth only, including X rays and cultures</p> <p>Periodontics, including:</p> <ul style="list-style-type: none"> • Gingival curettage • Gingivectomy • Osseous surgery • Scaling and root planing <p>If more than one surgery is performed at the same time, the more comprehensive procedure is covered by the option</p> <p>Additions to partial dentures to replace extracted teeth</p> <p>Repair or re-cementing of crowns, inlays, bridgework or dentures</p> <p>Diagnosis and non-surgical treatment of temporomandibular joint dysfunction, if the treatment is not otherwise excluded from coverage</p> <p>Inlay restorations, if the tooth cannot be restored by other means because of extensive caries or traumatic injury</p> <p>Crowns (single restorations), if the tooth cannot be restored by other means because of extensive caries or traumatic injury</p> <p>Initial installation of fixed bridges, bridge pontics or crowns to form abutments</p> <p>Initial installation of partial or full removable dentures, including adjustments to such dentures within 6 months of initial installation</p> <p>Initial installation of a permanent full denture that replaces a temporary denture if it is installed within 12 months of the temporary denture</p>	<p>Option pays according to a schedule of benefits. Call Aetna USHC Member Services to request benefit information for a particular procedure or to obtain a copy of the schedule</p>

Option Feature	Benefit
<p>Replacement or modification of an existing full removable or partial denture or fixed bridge if it was installed at least 5 years prior to its replacement or additional extractions required the replacement</p> <p>Lab costs for relining complete upper or lower dentures: Excluding relining within 6 months of insertion</p> <p>Occlusal devices for teeth grinding (bruxism): Necessity determined by the Plan administrator</p> <p>Replacement of congenitally missing teeth</p> <p>Services for the detection, prevention and correction of malocclusion of teeth in relation to the jaw</p>	<p>Option pays according to a schedule of benefits. Call Aetna USHC Member Services to request benefit information for a particular procedure or to obtain a copy of the schedule</p>

Dental Maintenance Organization Option

The Dental Maintenance Organization (DMO) option is available to both CWA- and IBEW-represented associates.

How the DMO Works

With the DMO option, you receive a high level of coverage for your dental expenses. In addition, most benefits are not subject to annual or lifetime limits on coverage, except for orthodontia, which is limited to one full course of treatment per lifetime for each covered member. You must use a DMO personal dentist; otherwise, you will receive no coverage for your dental expenses because there is no out-of-network benefit with the DMO.

However, some states require certain minimum benefit payments when you use a nonparticipating dentist.

Personal Dentists

When you join a DMO, you will need to choose a personal dentist from the DMO network. Your personal dentist will be your primary dentist who coordinates care if you need to see a dental specialist. In general, if you don't receive care from or you are not referred by your personal dentist, you will receive no coverage for your dental expenses.

You may select a different personal dentist for each family member. You can change your personal dentist up to once a month by calling the DMO administrator (see your Important Benefits Contacts insert for the telephone number).

If your personal dentist leaves the DMO, you must select another DMO personal dentist. You cannot change your dental option for this reason.

A list of personal dentists can be obtained by calling Aetna USHC at the telephone number listed on your Important Benefits Contacts insert. Aetna USHC also has an Internet site where you can get information about personal dentists online.

Important Note

The DMO is offered to you regardless of where you live and where DMO dentists are located. Before you enroll, make sure providers conveniently are located to you.

Emergencies

The DMO does require you to contact your personal dentist first when you need emergency dental care. If for any reason you are unable to contact your personal dentist, contact Member Services. You should check with the claims administrator for details on emergency coverage.

Overview of Benefits

Covered Procedure/Feature	Benefits Using DMO Personal Dentist (otherwise, generally no coverage)
Annual deductible	None
Preventive and diagnostic care (for example, cleanings and X rays)	Option pays 100%
Basic care (for example, fillings, most oral surgery and root canals)	Option pays 100% (certain services covered at 60%) ¹
Major care (for example, crowns, bridgework and dentures)	Option pays 60%
Orthodontia	Option pays 50%
Annual benefit maximum (excluding orthodontia)	None
Orthodontic lifetime benefit maximum ²	Limited to one full course of treatment per lifetime per covered person

¹Certain restorative services, molar root canals, osseous surgery, removal of full or partial bony impacted teeth and general anesthesia are covered at 60 percent.

²The lifetime orthodontic benefit maximum is a single lifetime maximum for all Verizon coverage and is in addition to the separate annual benefit maximum. If any individual you cover meets the benefit maximum for orthodontia, that individual does not gain a new lifetime orthodontic benefit maximum if you change options.

Waiver of Coverage Option

The waiver of coverage option is available to full-time CWA- and IBEW-represented associates who are covered as dependents under another Verizon-sponsored Dental Plan.

Part-time CWA- and IBEW-represented associates who do not receive the full Company subsidy for dental coverage can waive coverage for any reason. Part-time associates who receive the full Company subsidy can waive coverage only if they are covered as dependents under another Verizon-sponsored Dental Plan.

When you waive coverage for a calendar year, your election will remain in effect for each subsequent year unless you enroll in a dental coverage option during the open enrollment period or if you have a change in status (see [pages 9 through 11](#)) that allows you to elect coverage before the open enrollment period.

Continuing Coverage

Generally, your coverage or a dependent's coverage will end when your eligibility or a dependent's eligibility for the Plan ends. In some circumstances, however, coverage can be continued for a period of time if you agree to pay the cost.

Continuation of Coverage Under COBRA

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and its subsequent amendments provides special rules that allow you and your eligible dependents (qualified beneficiaries) to continue Plan coverage for a period of time after coverage otherwise would end. Special COBRA rules would apply if Verizon ever were to become bankrupt. For more information, contact the Plan administrator.

Eligible dependents include your spouse or same-sex domestic partner and children covered at the time coverage otherwise would end. Note that same-sex domestic partners are not included under COBRA rules, but Verizon has chosen to extend COBRA-like coverage to same-sex domestic partners in the same manner as an eligible covered spouse. Also, if you have or adopt a child or if a child is placed with you for adoption during the continuation period, you can add coverage for that child who then will become a qualified beneficiary. During the continuation period, you or your dependent must pay the full cost of the coverage on an after-tax basis, plus a two percent administrative charge, or 150 percent of the Company's cost during the 11-month period for which you have coverage because you or your eligible dependent is disabled.

Coverage continuation is available in the following situations:

- **If your coverage ends** because of termination of employment (except for gross misconduct) or retirement (including disability retirement) or because of a reduction in your work hours, you and your covered dependents can continue coverage for up to **18 months from the day coverage otherwise would end**. In addition, if you continue coverage and have or adopt a child or a child is placed with you for adoption during the COBRA continuation period, you can add coverage for that child, with coverage beginning immediately and lasting up to the end of your original 18-month coverage period.

If a dependent who is continuing coverage otherwise would become ineligible for coverage during the original 18-month coverage period because of your death, divorce or legal separation or the loss of dependent status, that dependent may elect to continue coverage for up to **36 months from the day coverage originally would have ended.**

If you or a covered dependent who is continuing coverage becomes totally disabled during the first 60 days of the COBRA continuation period or, for a totally disabled child born to, adopted or placed for adoption with a covered employee during the COBRA continuation period, during the first 60 days after the birth, adoption or placement of the child, a special rule applies. If the Social Security Administration determines that you or your enrolled dependent is disabled during the first 60 days of COBRA continuation coverage and the qualified beneficiary notifies the Company within 60 days of the Social Security Administration's determination and within the first 18 months of COBRA continuation coverage, coverage can be continued for you or your covered dependent for up to a total of **29 months from the date coverage originally otherwise would have ended.**

If the disabled person is among those electing continuation coverage, the cost for the additional 11 months of coverage will equal 150 percent of the cost to provide the coverage. If the disabled individual is not among those electing continuation coverage, those who elect continuation coverage will pay for the entire 29-month period at 102 percent of the cost to the Plan.

- **If your covered spouse or same-sex domestic partner or dependent child becomes ineligible for coverage** under the Plan because you become legally separated or divorced, your same-sex domestic partnership ends or you die, your spouse or same-sex domestic partner or children will have the opportunity to continue coverage for up to **36 months from the date coverage otherwise would have ended.**
- **If your dependent child becomes ineligible for coverage** under the Plan because of that child's age, loss of student status or marriage, your dependent child can continue Verizon coverage for up to **36 months from the date coverage otherwise would have ended.**

Note

Any period of COBRA continued coverage will run concurrent with (not in addition to) any period of continuation coverage provided under USERRA.

- **If your dependent loses coverage** under the Plan because, while you are an active employee, you elect to be covered by Medicare, your dependents can continue coverage for up to **36 months from the date coverage otherwise would have ended.**

Note: If the Company’s dental care coverage changes during the period that you, your spouse or same-sex domestic partner or your dependents are continuing coverage, the changes apply to your COBRA coverage and are applicable under your dental option.

Notification Requirements

To be eligible for COBRA continuation coverage for yourself or a dependent, you must notify the COBRA administrator within 60 days from the later of the date of the event that causes you or your dependent to lose coverage or the date coverage ends. You also have 60 days to make your decision as to whether you will elect continued coverage. This 60-day period begins on the later of the date that coverage ends or the date the written notice of the right to continue coverage is provided to you or your dependent. If you elect continued coverage, that coverage will be effective on the date your prior coverage ended.

If you are terminated or lose coverage because of a reduction in work hours, you will receive additional information from the Company about your opportunity to continue coverage under COBRA. It is your responsibility, however, to notify the Company **within 60 days** when a spouse or dependent child becomes ineligible for coverage, so he or she can receive information about continued coverage opportunities.

Paying for Your Continued Coverage

You have 45 days from the date of your election to continue coverage under COBRA to make your first payment. The first payment will include payment for your coverage prior to the date of your election. Payments will be due regularly thereafter. If you fail to make a required payment, your coverage will end 30 days after the required payment was due but not paid.

How Continued Coverage Could End

Continued coverage will end for you or your dependents on the date the earliest of these situations occurs:

- The period of continued coverage expires.
- The Plan is terminated by the Company.
- You do not make the required monthly payments on a timely basis.

Important Note

If you have questions about COBRA or wish to enroll, contact the COBRA administrator, ADP COBRA Services:

ADP COBRA Services
2155 West Park Court
Stone Mountain, GA 30087

See your Important Benefits Contacts insert for the telephone number.

- You or a dependent becomes eligible for coverage under another group dental plan (for example, a new employer) after electing COBRA, unless the new plan has a pre-existing condition limitation or exclusion that applies to you or your dependent. If a pre-existing condition does apply, this Plan will be primary only for covered services and supplies related to that condition; this Plan will be secondary for all other covered services and supplies.
- You or a dependent becomes entitled to Medicare after electing COBRA.
- You or a dependent ceases to be disabled during the special 11-month extension for a disabled individual.

What Is Not Covered

The Plan does not cover the following dental expenses for you or a covered dependent:

- Charges for broken or missed appointments
- Charges for completion or filing of claim forms
- Services or supplies that primarily are for cosmetic or aesthetic purposes, including personalization or characterization of dentures, facings on crowns and pontics posterior to the second bicuspid and the crowning of a tooth that has no decay but is out of line with other teeth
- Educational or training programs, such as oral hygiene and dietary instruction, or plaque control programs
- Replacement of teeth missing before the effective date of coverage, except:
 - Replacement of an existing partial denture, full removable denture or fixed bridge if the device is installed at least five years prior to its replacement
 - Replacement of a denture or bridge, while covered, if due to an additional extraction
- Topical application of fluoride to a prepared portion of a tooth prior to its final restoration
- Anesthesia, except intravenous sedation and general anesthesia when medically necessary in connection with oral surgery as determined by the claims administrator
- Additional units of general anesthesia or intravenous sedation
- Temporary appliances or restorations
- Replacement of missing, lost or stolen devices (including space maintainers) or extra sets of dentures or other appliances

- Services or supplies in connection with any duplicate prosthesis or other appliance; if you purchase a replacement for a missing, lost or stolen prosthesis, the rebasing, relining or repair of the prosthesis is a covered expense
- Treatment of problems of the jaw joint, including temporomandibular joint dysfunction, craniomandibular disorders and other conditions of the jaw joint and the complex of muscles, nerves and other tissues related to the jaw joint, except as otherwise provided
- Supplies used for the home application of fluoride
- Appliances to control the grinding of teeth, except when necessary as determined by the claims administrator; athletic mouthguards; and occlusal guards, except for treatment of temporomandibular joint dysfunction
- A restoration or crown, except for treatment of decay or traumatic injury that cannot be repaired with a filling material or for a tooth that is an abutment to a covered partial denture or fixed bridge
- Procedures determined by the claims administrator to be experimental
- Services rendered by an immediate family or household member
- Services not furnished by a dentist, except those performed by a dental hygienist under the direction of a dentist
- Charges in excess of the reasonable and customary (R&C) amount, preferred rate or scheduled amount, as applicable, or in excess of the applicable annual or lifetime maximum, as determined by the claims administrator
- Services or supplies for which there is no legal obligation to pay
- Services or supplies provided as the result of disease, defect or injury caused by declared or undeclared war while covered by the Plan
- Treatment resulting from insurrection or participation in a riot

- Services and supplies provided before the coverage effective date, including:
 - Any appliance or modification of an appliance if an impression was made prior to the coverage effective date
 - A crown, bridge or gold restoration if the tooth was prepared prior to the coverage effective date
 - Root canal therapy if the pulp chamber was opened prior to the coverage effective date

However, for the Standard Option and the DMO option, if orthodontia treatment started prior to the coverage effective date, treatment provided after the coverage effective date may be covered as determined by the claims administrator.

- For the PDP option and the Out-of-Area option, orthodontia treatment started prior to the coverage effective date
- Services or supplies provided after the coverage end date, except as otherwise provided
- Dental sealants, except as provided under the PDP, Out-of-Area and Standard options
- Implants
- Services or supplies provided in connection with surgical periodontics, including periodontal splinting
- Appliances, restorations and procedures to alter vertical dimension or restore occlusion, or to splint or correct attrition or abrasion
- Drugs and their administration
- Services or supplies covered under any federal or state “no-fault” motor vehicle insurance, regardless of whether you properly assert your rights under the motor vehicle insurance contract
- Services or supplies for which you recover the cost by legal action, insurance proceeds or settlement from a third party whose negligent or wrongful actions have caused or are alleged to have caused your injury that needs dental treatment or from the third party’s insurer
- Services or supplies provided by any local, state or federal government agency, except as otherwise required by federal law

- Services or supplies that are furnished, paid for or otherwise provided for treatment of a disability connected with military service or past or present service in the armed forces of a government, unless payment is required by law
- Services or supplies covered under the Verizon Managed Care Network and Medical Expense Plan for Mid-Atlantic Associates or any other Plan of Verizon or an affiliate (such as impacted teeth extractions for employees covered under the PDP or Out-of-Area option in Delaware, New Jersey and Pennsylvania); charges for treatment of accidental injury to natural teeth while covered under the Plan that total \$250 or less are covered under the Plan
- Services or supplies for a condition covered under Workers' Compensation laws or for any other occupational condition, ailment, injury or disease occurring on the job for all employees and dependents if:
 - The covered person's employer provides reimbursement for such charges or makes a settlement for such charges
 - The covered person fails to assert his or her rights to receive employer reimbursement

The Plan has the right to recover or place a lien on any benefits if Workers' Compensation provides benefits for the same condition.

- Services or supplies that are not necessary for treatment of injury or disease or not rendered in accordance with accepted standards of dental practice as determined by the claims administrator.

How to File a Claim

When you choose coverage under the Standard Option or the Out-of-Area Option, you must file claim forms. An advantage of the Preferred Dentist Program (PDP) and the Dental Maintenance Organization (DMO) is that you normally will not have to file claims.

When Claims Are Required

If you participate in the PDP or the DMO, your participating dentist will file claims for you. You will not have to file a claim form unless you go outside the network or receive emergency dental care when you are away from home.

When you participate in the Standard Option or the Out-of-Area Option or if you use a nonparticipating dentist, you will have to file claim forms to be reimbursed. To file a claim:

- If you need a dental claim form, call the InTouch Center or the claims administrator to get one.
- Ask your dentist to complete the balance of the claim form and return it to you. If he or she prefers to use another form, it should be attached to the claim form you provide.
- When dental work has been completed, sign the claim form to:
 - Authorize the dentist to release the information the claim administrator requires
 - Certify the employee/patient information is correct
 - Authorize payment directly to the dentist if the dentist does not require full payment from you
- Send the form to the claims administrator.
- Claims must be filed within 15 months from the date services are rendered.

Coordination of Benefits

Coordination of benefits (COB) rules are designed to prevent duplicate payments for the same service when you or your dependents are covered by more than one dental plan. When benefits coordinate, one plan will pay benefits first (the primary plan), another second (the secondary plan) and so on.

When the Plan is primary, it pays benefits based on the provisions described in this summary plan description (SPD).

When the Plan is secondary, the claims administrator subtracts the primary plan's payment from the actual charge. The Plan's secondary payment (if any) and the primary plan's payment, added together, never will exceed 100 percent of the actual charge.

If you have coverage through a prepaid dental plan (such as a DMO), coordination will be based on the reasonable cash value of each service provided under the Plan for purposes of determining if the Plan will pay a benefit as the secondary plan.

Priority of Payment

Under the Plan's COB provisions, the order of payment is as follows:

- A plan that covers a patient as an active, inactive or former employee pays before a plan that covers the patient as a dependent.
- For a dependent child, the Company uses the "birthday rule." This means that if a child is covered by both parents' group dental coverage, the plan of the parent whose birthday falls first during the calendar year pays benefits first. So, if the mother's birthday is April 27 and the father's birthday is October 23, the mother's plan pays benefits first. The parent's age has no effect on whose plan pays benefits first. If, however, the plan covering the parent who is not a Plan participant does not use the birthday rule, that plan pays benefits first.
- In the case of a divorce or separation, the plan of the parent with court-ordered financial responsibility for the dependent child pays benefits for the child first. If there is no court order establishing financial responsibility or if both parents have joint legal custody, the plan of the parent with physical custody of the child pays first. If the court order provides they have joint physical custody, the birthday rule applies.

Note: If both parents elect coverage under a Verizon-sponsored Dental Plan, their child can be covered under only one parent's Plan.

When the previous rules do not establish an order of benefit determination, the plan that covers the person as an active employee is the primary plan and the plan that covers the person as an inactive or former employee is the secondary plan. If this rule does not establish an order of benefit determination, the plan that has covered the person for the longer period of time is the primary plan and the plan that has covered the person for the shorter period of time is the secondary plan.

A plan that does not have a COB feature is considered the primary plan.

For active associates and covered persons eligible for Medicare, the Plan automatically still is the primary plan.

Subrogation and Third-Party Reimbursement

If you recover any charges for covered expenses from a third party (for example, as a result of a lawsuit from an automobile accident), the Plan's provision for subrogation and reimbursement takes effect. Under these procedures, the claims administrator's subrogation vendor tries to recover money that has been paid (or should be paid) on behalf of a third party (the other driver, in this example) whose negligence or wrongful actions caused illness or injury to a Plan participant. In this example of a car accident, should the Plan provide benefits because of your accident, the Plan has the right to recover the amount of those benefits from the negligent person or by obtaining a reimbursement from that person's insurance company—or from you if settlement amounts have been paid to you by the negligent person or his or her insurer.

The subrogation and reimbursement provisions also mean that if you make a liability claim against a third party after you have received benefits from the Plan, you must include the amount of those benefits as part of the damages you claim. If the claim proceeds to a settlement or judgment in your favor, you must reimburse the Plan for the benefits you received. You and your dependents must grant a lien to the Plan and you and your dependents must assign to the Plan any benefits received under any insurance policies or other coverages. As a condition of eligibility for benefits, you and your dependents must agree to cooperate with the claims administrator's subrogation vendor in carrying out the Plan's subrogation and reimbursement rights. Cooperation means you must respond promptly and fully with inquiries from the claims administrator's subrogation vendor and take what action the claims administrator's subrogation vendor requests to help recover the value of benefits provided under the Plan. If you don't, any amounts which could have been recovered through subrogation may be deducted from future Plan payments. In any case, Verizon will require payment from you only for amounts recovered that are net of your legal costs related to the action.

The covered person must sign any documents requested by the Plan to enable the Plan to exercise its rights under this provision.

The Plan is not responsible for your legal costs.

Right of Recovery

If, for any reason, the Plan pays a benefit that is larger than the amount allowed, the claims administrator has a right to recover the excess amount from the person or agency who received it. The person receiving benefits must produce any instruments or papers necessary to ensure this right of recovery.

Additional Information

Claims and Appeals Procedures

The authority and discretion to designate each of the claims and appeals administrators is granted to the Verizon Employee Benefits Committee (VEBC), formerly named the Bell Atlantic Corporate Employees' Benefits Committee, and the Verizon Claims Review Committee (VCRC), and to the individuals who chair each of these committees. Each of them has the discretion to designate the claims and/or appeals administrator from time to time. Furthermore, the VCRC (and its chairperson) has the discretion to designate the VCRC as a "final appeals administrator," either in place of the existing appeals process under the Plan, or as an additional level of appeal beyond the existing two-tier or three-tier claims and appeals process, depending on whether a final appeals administrator has been appointed. If a final appeals administrator has been designated, the final appeals administrator has sole authority to exercise discretion in review and resolution of a final appeal of a claim denied upon initial appeal under the Plan.

At the time of publication of this summary plan description (SPD), there are several claims and appeals administrators for the Plan:

Claims Regarding Eligibility to Participate in the Plan

Verizon's Bell Atlantic InTouch Center (staffed by PricewaterhouseCoopers LLP—or its successor) has discretionary authority to determine claims and appeals related to eligibility and enrollment in the Plan.

Claims Regarding Scope/Amount of Benefits Under the Plan

The following claims and appeals administrators have discretionary authority to determine claims and appeals for Plan benefits:

Option	Claims and Appeals Administrator
PDP and Out-of-Area options	Metropolitan Life Insurance Company (MetLife)
Standard Option	Aetna USHC
DMO option	Aetna USHC

The addresses of the claims and appeals administrators for the Plan are listed on [pages 52 through 53](#). If you have a claim or appeal, you should contact the appropriate claims and appeals administrator for the type of claim or appeal you have.

The claims and appeals administrators have discretionary authority to:

- Interpret the Plan based on its provisions and applicable law and make factual determinations about claims arising under the Plan
- Determine whether a claimant is eligible for benefits
- Decide the amount, form and timing of benefits
- Resolve any other matter under the Plan that is raised by a participant or a beneficiary, or that is identified by either the claims or appeals administrator.

The claims and appeals administrators have sole discretionary authority to decide claims under the Plan and review and resolve any appeal of a denied claim. In case of an appeal, the claims and appeals administrators' decisions are final and binding on all parties to the full extent permitted under applicable law, unless the participant or beneficiary later proves that a claims or appeals administrator's decision was an abuse of administrator discretion.

Filing a Claim

You, your beneficiaries or someone claiming benefits through you as a participant has the right under the Employee Retirement Income Security Act of 1974 (ERISA) and its subsequent amendments to file a claim if you believe you are entitled to benefits and benefits have been denied or incorrectly determined under the Plan.

To submit a claim, put your concern in writing, explaining in your own words your understanding of your benefit issue, and provide any supporting information in writing to the appropriate claims administrator.

The health and welfare benefit plans subject to open enrollment have two claims and appeals administrators:

- The administrator for claims and appeals that pertain to eligibility to participate in the Plan or issues relating to enrollment or changes in enrollment under the Plan (see [page 45](#))
- The administrator for claims and appeals that pertain to the scope or amount of benefits under the Plan (see [page 45](#)).

Once you have documented your claim and submitted any further information that you believe should be taken into account by the claims administrator, the claims administrator has 90 days to process your claim after receiving it.

If there are special circumstances requiring longer review, the claims administrator may take up to an additional 90 days to make a decision on your claim. The claims administrator will notify you in writing if more time is needed and of the final decision.

If Your Claim Is Denied

If your claim completely or partially is denied, a written notice of denial will tell you the specific reasons for the decision, the Plan provisions used to support the decision, a description of any outstanding materials needed to approve the claim and how you can appeal the decision.

Filing an Appeal

You (the participant or beneficiary who filed a claim that was denied) may file an appeal if:

- You receive no reply to your original claim within the initial 90 days
- The time for a decision on your original claim was extended for an additional 90 days, and you receive no reply after the additional 90 days
- You receive written denial of all or part of the claim and you want to appeal the denial.

You may appeal by submitting in writing a letter requesting an appeal and stating your concerns and any related facts to the appeals administrator. Your appeal letter must be received by the appeals administrator within 60 days after you receive the denial of your claim or fail to receive timely notice of a decision.

If you submit an appeal, you have the right to:

- Review pertinent Plan documents, which you can obtain as described on [page 49](#).
- Send a written statement of the issues and any other documents in support of your claim to the appeals administrator.
- Request copies of written documents that are relevant to your appeal. There typically will be a reasonable charge per page.

Review of Your Appeal

The appeals administrator will review your appeal of the denied claim and will make a decision within 60 days after receiving your written request for review. Your appeal will be decided by a different appeals administrator or committee than the appeals administrator or committee that decided your initial claim. If the appeals administrator meets on a quarterly basis, a decision may be made at the next quarterly meeting.

If the appeals administrator needs more than 60 days or a period beyond the next quarterly meeting to make a decision, you will be notified in writing, within the initial 60-day period or calendar quarter, and you will be told why more time is needed. The extension, if needed, will be an additional 60 days or until the subsequent quarterly meeting.

Normally, the appeals administrator will notify you of the decision in writing. However, if you do not receive a decision or notification within the appropriate time span, you should consider the appeal denied.

In case of an appeal, the appeals administrator's decision is the final, conclusive and binding administrative remedy under the Plan. However, as a Plan participant, you may have further rights under ERISA after you have exhausted the claims and appeals process, as described in the next section.

Benefits under this Plan will be paid only if the applicable benefit administrator or, in the case of a claim or appeal, the applicable claims or appeals administrator, or its delegate, decides in its discretion that the participant or beneficiary is entitled to them.

Peer Review

If you disagree with the claims administrator's resolution of a claim and did not previously agree to the charge, you can request a peer review. Peer review is a self-imposed professional discipline established at the local, regional or state level by the American Dental Association. Under peer review, independent committees are established to hear cases and resolve fee disputes. Contact the claims administrator for more information.

Proof of Loss

The claims administrator has the right to require verification of any information supplied as part of a claim. This includes requesting itemized bills for treatment (such as course of treatment for orthodontia), as well as medical and dental records. Claims will not be considered for reimbursement until requested information is received by the claims administrator. The following are acceptable means of verification:

- Dentist's written certification—claim form, letter, etc.
- Receipt for payment from dentist
- Employee's cancelled check, if dentist refuses to provide a receipt for payment.

Rights of Participants and Beneficiaries Under ERISA

Under ERISA, you have the following rights:

- You may examine all Plan documents without charge. These include annual financial reports, Plan descriptions, collective bargaining agreement provisions pertaining to the Plan and all other official Plan documents and reports, including a copy of the latest annual report (Form 5500 Series) filed with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefits Administration. The Plan administrator makes these documents available for examination free of charge at specified sites, such as Verizon work locations. For information, write to the Plan administrator:

c/o Verizon Benefits Center
100 Half Day Road
P.O. Box 1457
Lincolnshire, IL 60069-1457

Also, you may obtain copies of all Plan documents and other Plan information upon written request to the Plan administrator at the above address. Please include the full name of the Plan in your written request along with your name, Social Security number, mailing address and telephone number. You may be charged 25 cents per page for documents that you request.

- You will receive a summary of the Plan's annual financial report. The Plan administrator is required by law to furnish you with a copy of this summary annual report.

In addition to creating rights for Plan participants, ERISA imposes duties upon the persons who are responsible for the operation of the Plan. The persons who operate your Plan, some of whom are named as “fiduciaries” of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.

No one, including your employer, your union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA. If your claim for a benefit is denied or ignored, in whole or in part, you have the right to know why this was done and to obtain copies of documents relating to the decision without charge.

You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the previous rights.

For instance, if you request materials from the Plan administrator that you have a right to receive and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan’s money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees (for example, if it finds your claim to be frivolous).

If you have any questions about the Plan, you should contact the InTouch Center, which the Plan administrator has established for purposes of administering benefits and responding to questions of participants and beneficiaries. If you have any questions about this statement or about your rights under ERISA or if you need assistance in obtaining documents from the Plan administrator, you can contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries; Pension and Welfare Benefits Administration; U.S. Department of Labor; 200 Constitution Avenue, N.W.; Washington, D.C. 20210.

You also may obtain certain publications about your rights and responsibilities under ERISA by calling the publication hotline of the Pension and Welfare Benefits Administration.

Administrative Information

Administrative information about the Plan is provided in this section.

Important Telephone Numbers

See your Important Benefits Contacts insert for information.

Plan Sponsor

The Plan sponsor is:

Verizon Communications Inc.
4 West Red Oak Lane
White Plains, NY 10604

Plan Administrator

The Plan administrator is:

Chairperson of the VEBC
c/o Verizon Benefits Center
100 Half Day Road
P.O. Box 1457
Lincolnshire, IL 60069-1457

You may communicate to the Plan administrator in writing at the address above. But, for questions about Plan benefits, you should write or call the InTouch Center (see [page 52](#) for the address and your Important Benefits Contacts insert for the telephone number). The InTouch Center administers enrollment and handles participant questions, requests and certain benefits claims, but is not the Plan administrator. Claims relating to the scope and amount of benefits under the Plan are administered by the administrators listed on [page 45](#).

The Plan administrator or a person designated by the administrator has the full and final discretionary authority to publish the Plan document and benefit Plan communications, to prepare reports and make filings for the Plan and to otherwise oversee the administration of the Plan. However, most of your day-to-day questions can be answered by the Plan's benefits administrator or an InTouch Representative.

Do not send any benefit claims to the Plan administrator or to the legal department. Instead, submit them to the claims administrator for the Plan (see [page 45](#)).

Benefits Administrators

The benefits administrators have authority and responsibility to perform daily administration of benefits under the Plan.

- Aetna USHC is the benefits administrator for the Standard Option and the Dental Maintenance Organization (DMO) option. (See [page 53](#) for the address for the benefits administrator.)
- Metropolitan Life Insurance Company (MetLife) is the benefits administrator for the Preferred Dentist Program (PDP) option and the Out-of-Area option. (See below for the address for the benefits administrator.)

See your Important Benefits Contacts insert for the telephone numbers for the benefits administrators.

Claims and Appeals Administrators

There are several claims and appeals administrators for the Plan.

Verizon's Bell Atlantic InTouch Center (staffed by PricewaterhouseCoopers LLP—or its successor)

The InTouch Center is responsible for enrollment and eligibility claims. The InTouch Center can be reached at the following address:

Verizon's Bell Atlantic InTouch Center (or its successor)
P.O. Box 435
Little Falls, NJ 07424

See your Important Benefits Contacts insert for the telephone number.

Metropolitan Life Insurance Company (MetLife)

Under the PDP and Out-of-Area options, MetLife is the benefits administrator responsible for exercising the discretion to determine benefit payments, and also is the claims administrator for claims relating to the scope or amount of benefits under these options. MetLife can be reached at the following address:

Metropolitan Life Insurance Company
MetLife Dental
P.O. Box 14093
Lexington, KY 40512-4093

See your Important Benefits Contacts insert for the telephone number.

Aetna USHC

Under the Standard and DMO options, Aetna USHC is the benefits administrator responsible for exercising the discretion to determine benefit payments, and also is the claims administrator for claims relating to the scope or amount of benefits under these options. Aetna USHC can be reached at the following addresses:

Standard Option

Aetna USHC
P.O. Box 15115
Albany, NY 12212-5115

See your Important Benefits Contacts insert for the telephone number.

DMO Option

Aetna USHC
P.O. Box 15046
Albany, NY 12212-5046

See your Important Benefits Contacts insert for the telephone number.

QMCSOs

The firm responsible for the administration of qualified medical child support orders (QMCSOs) is Hewitt Associates LLC. Hewitt Associates LLC can be reached at the following address:

Hewitt Associates LLC
c/o Verizon Benefits Center
100 Half Day Road
P.O. Box 1457
Lincolnshire, IL 60069-1457

Plan Funding

PDP, Out-of-Area and Standard Options

The Plan is not financed by an insurance company, nor are Plan benefits guaranteed under a contract of insurance. The claims and appeals administrators listed on [page 45](#) do not insure or guarantee Plan benefits.

The Company has the discretion to pay claims out of the general assets of the Company, and certain benefits currently are funded through a trust.

The trustee is:

Mellon Bank, N.A.
c/o Patricia Farbacher
Vice President
One Mellon Bank Center - Room 3346
Pittsburgh, PA 15258

DMO Option

The DMO option is fully insured through Aetna USHC. The Company and employees pay premiums to the insurance company for coverage.

Plan Identification

Dental coverage is provided through the Verizon Dental Expense Plan for Mid-Atlantic Associates, which is a component plan of Verizon Plan 550. It is a welfare plan, listed with the Department of Labor under two numbers: The Employer Identification Number (EIN) is 23-2259884 and the Plan Number (PN) is 550.

In addition to the benefits described in this SPD, Verizon Plan 550 provides other benefits to Mid-Atlantic associate employees of Verizon (including Connected Solutions Inc. technicians) who will receive their own version of the SPD. Dental benefits for Connected Solutions Inc. technicians are provided under the Verizon Dental Expense Plan for Mid-Atlantic Associates. Medical benefits are provided under the component plans referred to as the Verizon Managed Care Network and Medical Expense Plan for Mid-Atlantic Associates and the Connected Solutions Managed Care Health Plan. Vision benefits are provided under the component plans referred to as the Verizon Vision Care Plan for Mid-Atlantic Associates and the Connected Solutions Vision Care Plan. Medical and vision benefits are described in separate SPDs.

Plan Year

Plan records are kept on a Plan-year basis, which is the same as the calendar-year basis.

Agent for Service of Legal Process

The agent for service of legal process is the Plan administrator. Legal process must be served in writing to the Plan administrator at the address stated for the Plan administrator on [page 51](#).

In addition, a copy of the legal process involving this Plan must be delivered to:

Verizon Legal Department
Employee Benefits Group
Verizon Communications Inc.
1095 Avenue of the Americas
37th Floor
New York, NY 10036

Legal process also may be served on the trustee.

Official Plan Document

This SPD is part of the official Plan documents.

Participating Companies

The following is a list of participating companies as of January 1, 2001. The list may change from time to time.

- Verizon Advanced Data Inc.
- Verizon Delaware Inc.
- Verizon Directory Services Inc.
- Verizon Maryland Inc.
- Verizon New Jersey Inc.
- Verizon Pennsylvania Inc.
- Verizon Services Corp.
- Verizon Virginia Inc.
- Verizon Washington, D.C. Inc.
- Verizon West Virginia Inc.

Glossary

C

COBRA

A federal law (Consolidated Omnibus Budget Reconciliation Act of 1985 and its subsequent amendments) allowing continuation of Plan coverage for a period of time at the participant's expense if a participant loses eligibility because of certain changes in status.

Covered Person

Any employee and his or her dependents enrolled in the Plan, or any eligible individual who has elected coverage under COBRA.

Covered Services

The services, treatments or supplies identified as payable in the official Plan document. Covered services must be medically necessary as determined by the claims administrator to be payable.

D

Deductible

The amount of covered expenses you pay before certain options pay benefits for specific care.

Dental Hygienist

A person who is trained to remove calcium deposits and stains from the surfaces of the teeth and is licensed as required by the jurisdiction in which he or she practices.

Dentist

A person who is licensed to practice dentistry and administer treatment or perform dental surgery.

L

Legally Separated

An employee and his or her spouse are legally separated if they do not live together and if they have a signed document or a legal proceeding, such as a separation agreement, that indicates that the employee or his or her spouse intends to live separately.

P

Participating Company

Verizon or any corporation or partnership which is an affiliate of Verizon that has elected to participate in the Plan.

Preferred Rate

The fee that participating dentists have agreed with the benefits administrator to accept as payment in full for covered services and supplies provided to Preferred Dentist Program (PDP) participants. These rates also are applicable to services obtained from a participating dentist under the Out-of-Area option.

R

Reasonable and Customary Charge

The reasonable and customary (R&C) charge is the lesser of the actual charge or the maximum fee allowance for a covered service or supply. The benefits administrator determines the R&C charge.

The maximum fee allowance is determined by taking into consideration the following:

- The fee most commonly charged by a majority of providers in a given geographic area where those providers have similar training in the performance of the procedures
- The fee normally charged by that provider for a similar service or supply
- The amount charged for unusual circumstances or complications requiring additional time, skill and experience in connection with that particular dental service, supply or procedure.

S

Same-Sex Domestic Partner

To qualify as a Class I Dependent, your same-sex domestic partner must meet all of the following criteria:

- Is an adult of the same sex as you
- Is not married to anyone else
- Is not the domestic partner of anyone else

- Is your only domestic partner and intends to remain so indefinitely
- Is not related to you by blood that would prevent marriage under the law
- Lives with you in the same permanent residence
- Is jointly responsible, along with you, for one another's welfare and for basic living expenses
- Is at least 18 years old and competent to contract under the law.

In addition, if you disenroll your partner, you must wait 60 days before enrolling a new partner.

You must agree to notify the InTouch Center if your partner no longer meets the criteria listed above.

Scheduled Amount

The maximum benefit payable for a specific covered service or supply, as determined by the claims administrator. If the schedule does not indicate an amount for a specific covered service or supply, the scheduled amount is calculated as 75 percent of the applicable R&C amount.

W

Working Retiree

A former associate employee of a participating company (other than Verizon Delaware Inc., Verizon Pennsylvania Inc., Verizon Directory Services or Verizon Connected Solutions Inc.) who was represented by CWA immediately prior to leaving the Company and:

- Who retired on a service pension or who elected a service pension cashout under the Verizon Pension Plan for Mid-Atlantic Associates
- Who is reemployed by a participating company after 90 or more days of retirement
- Whose reemployment lasts 120 or fewer days in a calendar year.